NEW YORK CENTER FOR SPECIALTY SURGERY

PATIENT SCHEDULING SHEET

Fill out and fax to scheduler with any Physician's "Pre-Surgical Orders" to:
Scheduling Fax: 347-599-2633
Scheduling Phone: 347-599-2100

PATIENT INFORMATION

Date of Procedure:	Mon Tues Wed Thurs Fri Sat	Scheduled Time: AM PM	Procedure Length:
Patient's Name: (Last)	(First)	(MI)	Surgeon:
Address:			Assistant:

City:	State:	Zip:	Previous Patient? Yes No	23 HR Stay? Yes No
Social Security Number:		Date of Birth:	Age:	Sex:

Home Phone:	Cell Phone:	Anesthesia Type: General MAC Local Block Choice Conscious Sedation	
Best number to contact yo Home Cell	May we leave a message? Home: Yes No	Cell: Yes No	Emergency Contact: Phone: Relation:

Pre-op DX / ICD 9 Code:

Procedure(s)/**CPT Codes**:

Special Equipment Needs:

INSURANCE INFORMATION

Responsible Party Name and Address (if different than above):

Relation to Responsible Party: Self Child Spouse Other	Responsible Party SS#:	Responsible Party Employer:	Responsible Party Phone:

Primary Insurance Carrier / Name of Insured	**Secondary** Insurance Carrier / Name of Insured:
Insurance Billing Address and Phone	Secondary Billing Address and Phone:

ID / SS#:	Group #:	Authorization #:	ID / SS#:	Group #:	Authorization #:
Insured's Employer and Phone #:			Insured's Employer and Phone #:		

Worker's Comp Info:	D.O.I.:	Claim #:	Adjustor:

PRE-ADMISSION PHYSICIAN ORDERS

Testing: o H & H o FBS if diabetic o Urine Preg o EKG	H&P Dictated: o No o Yes
For Local or Conscious Sedation: o Start IV of Lactated Ringers o No IV	Date:
	Job #:

Date: Time: Signature: